

471-000-94 Instructions for Completing Form MC-84, "Personal Assistance Provider Check List"

Use: Local office staff begins completing Form MC-84 at the start of enrollment and continue completing the form throughout the enrollment process.

Number Prepared: Two copies of Form MC-84 are completed.

Completion: Local office staff completes Form MC-84 as follows:

Enter the personal assistant's name and the date that the enrollment process is initiated.

Check the appropriate requirements during the interview and enrollment process.

General Requirements are verified at the initial interview.

Personal Assistance Provider Requirements are checked during the interview as the services required are discussed with the potential provider.

Forms Completion is checked as each item is completed.

Signature: The provider and the local office worker signs Form MC-84.

Distribution: After completion, the worker files the white copy in the provider's file and gives the yellow copy to the provider.

Nebraska Department of Health and Human Services  
Medical Services Division  
**PERSONAL ASSISTANCE PROVIDER CHECK LIST**

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



Provider Name \_\_\_\_\_

Date \_\_\_\_\_

**GENERAL REQUIREMENTS:**

- \_\_\_\_\_ Is age 19 or over.
- \_\_\_\_\_ Is not financially responsible for the client.
- \_\_\_\_\_ Is physically healthy and capable.
- \_\_\_\_\_ Evidences maturity.
- \_\_\_\_\_ Understands and agrees to comply with right of client to confidentiality and privacy.
- \_\_\_\_\_ Evidences ability to work with Agency.
- \_\_\_\_\_ Has appropriate experience or training.
- \_\_\_\_\_ Has general understanding of P.A. Provider functions.
- \_\_\_\_\_ Has clear record with child/adult abuse/neglect registry.

**BASIC PROVIDER QUALIFICATIONS PERSONAL CARE AID REQUIREMENT**

- \_\_\_\_\_ Understands and accepts provider functions, rates, and limitations.
- \_\_\_\_\_ Understands and agrees with prior authorization of service.
- \_\_\_\_\_ Understands and agrees to complete and file billing forms within 90 days.
- \_\_\_\_\_ Agrees to accept payments as payment in full.
- \_\_\_\_\_ Agrees to sign provider agreement.
- \_\_\_\_\_ Agrees to provide necessary information/documentation to Agency and to retain documents four (4) years from date of service.
- \_\_\_\_\_ Agrees to notify client when unable to provide service.
- \_\_\_\_\_ Agrees to notify Agency when unable to provide service.
- \_\_\_\_\_ Agrees to notify Agency if terminating provider status.

**FORMS COMPLETION**

- \_\_\_\_\_ Provider Agreement (MILTC-9) has been signed and submitted to Central Office.
- \_\_\_\_\_ Copy of License/Certificate of Completion of an Approved Aid Course or has declaration of experience submitted to Central Office.
- \_\_\_\_\_ Physician's/RN's statement for health maintenance activities has been obtained and placed in client's case record. (MILTC-4D).
- \_\_\_\_\_ Personal Assistance Service Plan (MC-73) has been completed with the provider.
- \_\_\_\_\_ Manual material has been explained and given to the provider.
- \_\_\_\_\_ Provider Packet and Service Provider Time Sheet (Form MC-37) has been explained and given to the provider.
- \_\_\_\_\_ PA Claim Form (Form MC-82) and Notice/Authorization for Personal Assistance Services (MILTC-4B) have been explained and given to the provider.

Provider Signature \_\_\_\_\_

Local Office Staff \_\_\_\_\_

Distribution: WHITE COPY — Client Case Record YELLOW COPY — Provider